Electronically delivered

May 28, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number H5228017C

Dear Administrator:

On May 9, 2019, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 11, 2019.

Also on May 9, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy(ies):

- Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on April 22, 2019. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On May 24, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on April 22, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 17, 2019. We have determined, based on our visit, that your facility has corrected as of May 24, 2019.

As a result of the revisit findings:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 11, 2019 be rescinded as of May 24, 2019. (42 CFR 488.417 (b))

In our letter of May 9, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 22, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on

May 24, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 28, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Reinspection Results - Project Number H5228017C

Dear Administrator:

On May 24, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 22, 2019. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted

May 9, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number H5228017C

Dear Administrator:

On April 22, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 22, 2019, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 11, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 11, 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 11, 2019, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 22, 2019. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If

you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 22, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 22, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please note, it is your responsibility to share the information contained in this letter and the results of

this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	C 04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/18/19 through 4/22/19 an abbreviated survey was completed at your facility to conduct complaint investigation(s) H5228017C . Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint (s) was found to be substantiated: H5228017C deficiencies were issued at F600; related deficiencies were issued at F609. This survey resulted in an Immediate Jeopardy (IJ) and substandard quality of care at F600 The IJ began on 4/12/19, when nursing assistant (NA)-A struck R2 in the chest, and the facility failed to ensure all residents residing on the Meadows unit were protected from NA-A, who was allowed to continue working unsupervised after striking R2 in the chest. The facility administrator was notified of the IJ on 4/19/19, at 4:32 p.m. which was identifed as a pattern (K) The IJ was removed on 4/22/19, at 4:00 p.m. but non-compliance remained at the lower scope and severity of E, no actual harm with potential for more than minimal harm, that is not immediate jeopardy. An extended survey was completed on 4/22/19. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/17/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were protected from physical abuse when a nursing assistant struck 1 of 1 residents (R2). This resulted in an immediate jeopardy (IJ) situation with the potential to effect all 19 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19) residents residing on the Meadows unit. The IJ began on 4/12/19, when nursing assistant (NA)-A struck R2 in the chest, and the facility	F 600	Policy Review: Administrator and DON reviewed and revised the facilities Vulnerable Adult Policy on 4/19/19. Policy was updated to reflect that any staff person suspected of committing any form of abuse towards a resident will be immediately suspended until further investigation can take place. Vulnerable adult process maps reviewed/revised as necessary to reflect immediate reporting within 2 hours for any suspected abuse.	5/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

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F 600	Continued From page 2 failed to ensure all residents residing on the Meadows unit were protected from NA-A, who was allowed to continue working unsupervised after striking R2 in the chest. The facility administrator was notified of the IJ on 4/19/19, at 4:32 p.m. which was identified as a pattern (K) The IJ was removed on 4/22/19, at 4:00 p.m. but non-compliance remained at the lower scope and severity of E, no actual harm with potential for more than minimal harm, that is not immediate jeopardy. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/22/19, identified R2 had severe cognitive impairment with decreased decision making skills. R2 required extensive assistance with transfers and had daily verbal and physical behaviors. The MDS identified diagnoses of Alzheimer's disease, dementia, anxiety, and depression. R2's care plan dated 2/7/19, identified R2 required the assistance two staff for transfers and cares. R2 had known behaviors of hollering, throwing items, grabbing at staff, and making sexually inappropriate comments. Staff were to respond to R2's hollering as soon as possible to assess his needs of toileting, wanting to eat, change his position, and assess for pain. This usually stopped R2's hollering and disruption to others. If R2 appeared unapproachable, staff were to provide R2 with a safe place and re-approach later. There was no mention how staff were to handle aggressive behaviors if exhibited while staff were performing necessary care.	F 600	Education: Education was provided to all direct care staff on the vulnerable adult policies and reporting obligations. Vulnerable adult education included: definitions of what constitutes a vulnerable adult situation, mandated reporting, importance of immediate reporting, within 2 hours to supervisors and OHFC for suspected abuse, staff suspension if abuse/neglect is suspected. All staff working between 4/19/19-4/21/19 received education from administrator, DON and nursing supervisors. All staff scheduled after 4/21/19 received education prior to the start of their next scheduled shift. Quality Monitoring: Audits created to monitor residents with known history of behaviors. Tracking includes observation of staff interactions with residents, recognition of target behaviors, discussion/review of care plan interventions and effectiveness of current interventions. Results of audits will be reviewed at daily safety huddle with staff and summary of observations will be discussed at monthly LTC quality committee meetings. Audits implemented effective 5/17/19	

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F 600	Continued From page 3	F 600		

The facility investigation dated 4/13/19, 8:20 a.m. identified the report was made by registered nurse (RN)-A. The event date recorded was 4/12/19, at 8:30 a.m. R2 was aggressive toward staff during morning cares. NA-A reported the incident to RN-A around 10:00 a.m. NA-A had "tapped" R2 on shoulder and stated to R2 to "please to not hit us [staff]. We are trying to help you". Later on in the shift around 7:00 p.m. NA-B reported NA-A's tap was more like a "slight karate chop". RN-A indicated she would continue to monitor R2 for redness/bruising and had none noted at that time. RN-A's immediate action was identified as having a conversation with staff and included it was wrong to take out aggression towards a resident, no matter the situation. RN-A documented she would continue to monitor staff interaction with R2 throughout the weekend. Follow up documentation marked on the report was "Supervisor notified?: No. Family notified: No. Contact the provider [R2's physician (MD)]: No. Further information documented family had been notified the following day on 4/13/19 at 8:47 a.m. There investigation lacked how the facility was protecting R2 and the other residents on the unit from NA-A.

A State Agency (SA) report dated 4/15/19, identified the SA was notified on 4/15/19, at 11:15 a.m. The date of incident was identified as 4/12/19, at 6:00 p.m. The report identified the following: "Resident was struck by staff after he had hit out at her per typical behaviors and staff reportedly put hand/arm up, in reaction, which caused resident to be struck as well. This was reported by staff involved as well as another staff in room assisting with cares. Family Aware. Nursing assistants had reported this to nurse, who contacted administrator. Reported to local

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F 600	Continued From page 4	F 600		

law enforcement and nurse states VA [vulnerable adult report] filed. In follow up today, its noted that VA was not submitted per protocol-she was unable to log on to [SA] site and when submitting facility quality risk management report, she included [SA] email which she understood was going to be reported to state as VA this way."

The Marshall police department report dated 4/15/19, identified the following:

- The police were called to the facility on 4/13/19, at approximately 10:49 a.m. for a staff to resident incident. Officer (O)-A was notified by dispatch he could call the facility and contact registered nurse (RN)-A. O-A called RN-A who reported R2 had dementia and often was assaultive to staff. RN-A stated R2 struck one of the staff members (NA-A). NA-A had struck R2 back somewhere between his neck and shoulders. RN-A had checked on R2, and he was fine. NA-A was being monitored and not going into R2's room. RN-A had notified her supervisor and completed the reporting to the State Agency. RN-A was asked to complete a written statement to be included with his case file. At 3:00 p.m. that same day, O-A went to the facility to pick up RN-A's statement. Upon arrival O-A spoke with RN-A who reiterated R2 was becoming increasingly more combative to staff. O-A asked to speak with R2, but was told R2 would likely not provide an accurate detail of the incident due to his dementia. NA-A had self-reported to RN-A and advised her she struck R2 as a reaction of R2 striking her. NA-B and trained medication aide (TMA)-A had also been in the room at the time of the incident. All 3 staff were currently on shift. O-A asked to speak with them individually. RN-A's written statement identified

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	245228	A. BUILDING _____ B. WING _____	C 04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

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she had reported the incident to the facility administrator.

- NA-B was interviewed by O-A and reported TMA-A was also in R2's room getting his morning medication ready. NA-A and NA-B had been getting R2 up for the day and providing morning cares. R2 had a history of hitting staff. NA-A and NA-B were working with R2 while using a mechanical lift. NA-A was positioned on R2's right side, and NA-B had been on his left. R2 was being combative at NA-A and NA-B and hitting out at them. NA-B observed NA-A hit back at R2 in the upper chest area. NA-B believed her actions were "instinct". NA-B believed if newer staff [NA-A] had further training [with residents with behaviors], staff's instinct to strike back when hit by a resident could be managed better. NA-B had worked at the facility for 15 years and reported he had been hit by residents many times. NA-B reported he knew to keep his distance from R2 so he would not get hit. NA-B reported to O-A NA-A hit R2 with "more than a light hit, but not full force." NA-B reported R2 apologized as if he knew he was doing something wrong.

- O-A interviewed NA-A at that time. NA-A was willing to speak with the officer freely. NA-A reported she had been quite upset about the incident and the reporting that has resulted. NA-A indicated she was in R2's room getting him up for the day. NA-B and TMA-A also were present in the room. TMA-A was getting R2's morning pills ready. Immediately after the incident TMA-A had assisted NA-A and NA-B by trying to hold R2's hands. R2 had been in bed. NA-A and NA-B were in the process of cleaning R2 up, which he "didn't like". R2 would often wet or defecated in his briefs

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so staff would have to clean him up. R2 was known not to like it and often put his fists up and tried to hit at staff. NA-A was on R2's right side using a warm wash cloth to clean R2's private area. As she was doing this, NA-A reported R2 hit her in the throat and it startled her. She had a reflex reaction and hit R2 with the palm of her hand on his upper right shoulder. NA-A reported she had not hit R2 very hard and was just trying to keep his arm away from her. R2 would usually keep fighting with his hands and fists and staff would continue to clean him. NA-A stated she had been hit multiple times by R2, but never in the throat. NA-A was worried about the situation and had not intended to hurt R2. NA-A stated it had been a reflex reaction. NA-A reported R2 would often show staff his fists as if to threaten he was going to hit them. NA-A admitted to showing R2 her fists in return and would say something to the effect of "She can show her fists as well". NA-A reported she would never hit R2 in that situation, but rather showed him his "threats to staff were not okay." NA-A had been employed at the facility for two years.

- O-A spoke with TMA-A. TMA-A heard R2 hit NA-A, but had not witnessed it. It had sounded like a "slap or a punch that connected with a person's skin". TMA-A reported R2 normally would put his fists up as he had not liked his morning cares. NA-A had informed TMA-A R2 had hit her in the front of the neck and NA-A reacted by hitting R2 back. That surprised her as she did not hear a second hit. NA-A's neck was red at the time. TMA-A knew NA-A had reported the incident to her supervisor. TMA-A reported NA-A was "kind of jumpy" when R2 struck her in the neck related to past spousal abuse from NA-A's husband.

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F 600	Continued From page 7 - O-A identified the case should be sent to the Detective's Division for review. O-A identified he was unaware whether action had been taken to protect R2 from further harm. The facility schedule for 4/7/19, through 4/20/19, identified NA-A worked 4/12/19, 4/13/19 and 4/14/19. During interview on 4/18/19, at 11:36 a.m. nursing supervisor (NS)-B stated she first found out about the incident on 4/15/19. NS-B followed up with the administrator and RN-A who was on duty that day. RN-A had stated the incident was reported to her by NA-B at end of his shift on 4/12/19. NA-A had already gone home for the day at that time. RN-A had not notified the administrator until 4/13/19. At that time, the administrator instructed RN-A to contact law enforcement and submit a report to the State Agency. NA-A could remain on the schedule, but was not to work independently. NS-B logged into the state reporting website and found RN-A had not filed a report, as previously stated, so she immediately filed a report on 4/15/19. NS-B stated the investigation interviews by the facility were completed on 4/15/19. NA-A was placed on suspension on 4/15/19, by the administrator at that time. NA-A continued to work at the facility on 4/12/19, 4/13/19, and 4/14/19. Her understanding was NA-A did not work with R2 over the weekend and either RN-A or RN-C supervised NA-A on a 1:1 basis with the other residents. NS-B's expectation was to immediately report the incident according to facility policy. During interview on 4/18/19, at 2:44 p.m. NA-A stated on 4/12/19, R2 was hooked up to a	F 600		

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mechanical lift and she was standing in front of the lift when R2 struck her in the neck. NA-A stated, as a reflex, she struck R2 in the upper arm by R2's shoulder. NA-B was standing in front of lift and trained medication aide (TMA)-A was trying to get R2's medication ready to give R2. NA-A did not think TMA-A saw what happened. .Once TMA-A was aware of what happened, TMA-A tried to grab and hold R2 hands to prevent R2 from lashing out so R2 wouldn't hit at staff.. NA-A stated she frequently worked with R2 and had been hit by R2 several times. When R2 hit NA-A, it was sudden, in her neck and so strong it was shocking. NA-A stated she was startled and reacted. NA-A reported R2 will threaten staff by holding his fist up like he is going to hit someone. NA-A mirrored R2's actions before and has held up her firsts and shook them back at R2. Some days R2 had no behaviors and was in a good mood NA-A received no direction from RN-A after she reported what happened. NA-A continued to work with R2 and remained working independently with other residents. R2 continued to be combative that day. RN-A did have someone work with NA-A when she worked with R2 but she did not have any monitoring by anyone when she worked with other residents, nor was she told someone had to be with her. NA-A had previous training on abuse, reporting, and working with resident with dementia and behaviors. NA-A stated it would be nice to have more training. NA-A verified she did not have a another staff assigned to work with her on 4/12/19, 4/13/19 and 4/14/19 when she worked.

During interview on 4/18/19, at 3:12 p.m. NA-B stated he was in R2's room when NA-A struck R2 during morning cares. NA-A was in front of R2 on the right side and when NA-A was bending down

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R2 struck NA-A sideways in the neck. NA-A raised her arm with open hand and struck R2 back in chest. NA-B reported it might of been reaction, but felt NA-A needed "better training." NA-B reported the incident to RN-A on duty about one-half hour to forty-five minutes after it happened. NA-B also identified anytime NA-A worked with R2, NA-B needed to be in the room as he required 2 staff for assistance. NA-B indicated he was not instructed to work with NA-A for residents who only required one staff for cares. On 4/13/19, the police came to the facility to talk to staff regarding the event on 4/12/19. NA-B felt NA-A tried to minimize what happened on 4/12/19.

During interview on 4/19/19, at 8:51 a.m. TMA-A stated she was in the room when NA-A struck R2 but did not actually witness it. TMA-A heard what sounded like someone hitting skin. She believed the noise she hear had to be when R2 struck NA-A. TMA-A saw a red spot on NA-A's neck, after NA-A stated R2 hit her. TMA-A said NA-A reported she was scared that R2 "was really going to hurt her". TMA-A has been hit by R2 and saw other staff get hit by R2. TMA-A never saw anyone else react to R2 aggressive behaviors in the manner NA-A had. TMA-A stated was directed by RN-A there needed to be another person in the room when NA-A was providing care to R2, but not if NA-A was providing cares to the other 18 residents on the unit.

On 4/19/19, at 9:00 a.m. the medical director (MD) stated he was verbally notified "in a round about way" on 4/15/19, about the incident. MD was told NA-A had struck R2 after being struck by R2 during cares. MD's expectation was the facility staff were to follow policy and procedure for

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reporting and keeping residents safe. MD stated R2 had a history of being extremely challenging, however staff were not to hit a resident under any circumstances. MD expected the facility to suspend staff suspected of abuse immediately and throughout the investigation until it could be determined if abuse occurred.

When interviewed on 4/19/19, at 9:22 a.m. director of nursing (DON) stated she was not available on 4/12/19, and had not been notified of the incident. The administrator notified on 4/13/19, the day after the incident. The administrator directed RN-A to call law enforcement and have someone work along side of NA-A for the remainder of the weekend. DON stated staff were expected to report sooner. Normally, facility process was to protect residents by suspending the person immediately until an investigation was completed. Direction was given to the nurse by the administrator that NA-A was not to work with R2. During record review, She discovered NA-A had continue to work with R2 after the incident. NA-A had self-reported the incident to RN-A on Friday 4/12/19. RN-A had inappropriately supervised NA-A, and allowed NA-A to continue to work unsupervised. The DON stated NA-A was instructed to have someone with her at all times when providing cares. NA-A had been terminated as of 4/18/19. DON stated RN-A was on duty 4/13/19, and 4/14/19, and had not followed facility policy and procedure.

During interview on 4/19/19, at 2:04 p.m. administrator stated she was notified about the incident the morning of 4/13/19, by RN-A. She was told R2 hit NA-A, and NA-A hit R2 back. Her understanding was the incident occurred just before NA-A finished her shift on 4/12/19. RN-A

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F 600	Continued From page 11 stated a witness said it was "more than a tap". The administrator "walked RN-A through" making a report to the State Agency. She directed RN-A, NA-A should not work unless she can be with someone all the times, and to call the police because "it was an assault." The administrator expected staff were to call the police immediately. Staff failed to immediately begin the process according to policy, if abuse was suspected to have occurred. During interviews with staff on 4/15/19, the administrator discovered staff's versions of events had not been corroborated by one another. NA-A was suspended at that time. The facility Adult Abuse Prevention Plan dated 1/19, defined abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment, resulting in physical harm, pain, or mental anguish. Staff may be suspended or terminated in situations involving severe abuse / or neglect on part of the caregiver. The facility would provide for immediate safety of the resident. The IJ that began on 4/12/19, was removed on 4/22/19, at 4:00 p.m. when it was able to be validated the facility had established and implemented their removal plan by educating all nursing staff, suspending identified staff from resident care, and reviewing and updating policies.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		5/17/19

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F 609	Continued From page 12 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the administrator and State Agency (SA) were notified within 2 hours of accusations of physical abuse for 1 of 1 residents (R2) who was struck by a staff member Findings include R2's quarterly Minimum Data Set (MDS) dated 1/22/19, identified R2 had severe cognitive impairment with decreased decision making skills. R2 required extensive assistance with transfers and had daily verbal and physical	F 609	Policy Review: On 4/19/19 administrator and DON reviewed vulnerable adult process maps and reviewed/revised as necessary to reflect immediate reporting within 2 hours for any suspected abuse. Education: Education was provided to all direct care staff on the vulnerable adult policies and reporting obligations. Vulnerable adult education included: definitions of what constitutes a vulnerable adult situation,	

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F 609	Continued From page 13 behaviors. The MDS identifed diagnoses of Alzheimer's disease, dementia, anxiety, and depression. The facility investigation dated 4/13/19, at 8:20 a.m. identified an event occured on 4/12/19, at 8:30 a.m. The investigation identifed nursing assistant (NA)-A reported to registered nurse (RN)-A NA-A had "tapped" R2 on shoulder and stated to R2 to "please to not hit us [staff]. We are trying to help you". Later on in the shift around 7:00 p.m. NA-B reported NA-A's tap was more like a "slight karate chop". A SA report dated 4/15/19, identifed the SA was notified on 4/15/19, at 11:15 a.m. The date of incident was identifed as 4/12/19, at 6:00 p.m. The report identifed the following: "Resident was struck by staff after he had hit out at her per typical behaviors and staff reportedly put hand/arm up, in reaction, which caused resident to be struck as well. This was reported by staff involved as well as another staff in room assisting with cares. Family Aware. Nursing assistants had reported this to nurse, who contacted administrator. Reported to local law enforcement and nurse states VA [vulnerable adult report] filed. In follow up today, its noted that VA was not submitted per protocol-she was unable to log on to [SA] site and when submitting facility quality risk management report, she included [SA] email which she understood was going to be reported to state as VA this way." When interviewed on 4/19/19, at 9:22 a.m. director of nursing (DON) stated she was not available on 4/12/19, and had not been notified of the incident. The administrator was reported to be notified on 4/13/19, the day after the incident.	F 609	mandated reporting, importance of immediate reporting, within 2 hours to supervisors and OHFC for suspected abuse, immediate staff suspension if abuse/neglect is suspected. All staff working between 4/19/19-4/21/19 received education from administrator, DON and nursing supervisors. All staff scheduled after 4/21/19 received education prior to the start of their next scheduled shift. Quality Monitoring: DON will review all VA reports for timely submission beginning 5/17/19. Reports will be added to the quality scorecard and discussed monthly at the LTC quality committee meeting.	

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F 609	Continued From page 14 During interview on 4/19/19, at 2:04 p.m. administrator stated she was notified about the incident the morning of 4/13/19, a day after the incident. Her understanding was the incident occurred just before NA-A finished her shift on 4/12/19. The administrator "walked RN-A through" making a report to the SA. Staff failed to immediately begin the process according to policy, if abuse was suspected to have occurred. The facility Adult Abuse Prevention Plan dated 1/19, directed staff to report no later than 2 hours after an allegation was made, if the events that causes the allegation involve abuse, or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Immediate reports are to be made to the administrator of the facility.	F 609		

Electronically delivered
May 9, 2019

Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: State Nursing Home Licensing Orders - Project Number H5228017C

Dear Administrator:

The above facility was surveyed on April 18, 2019 through April 22, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00343	A. BUILDING: _____ B. WING _____	C 04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/18/19, through 4/22/19, surveyors of the Minnesota Department of Health completed an abbreviated survey to investigate complaint H5228017C. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint (s) was found to be substantiated: H5228017C deficiencies correction orders were issued at 1995 (626.557 Subd 4. a). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the administrator and State Agency (SA) were notified within 2 hours of accusations of physical abuse for 1 of 1 residents (R2) who was struck by a staff member. Findings include R2's quarterly Minimum Data Set (MDS) dated 1/22/19, identified R2 had severe cognitive	21995	corrected	5/17/19

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21995	Continued From page 2	21995		

impairment with decreased decision making skills. R2 required extensive assistance with transfers and had daily verbal and physical behaviors. The MDS identifed diagnoses of Alzheimer's disease, dementia, anxiety, and depression.

The facility investigation dated 4/13/19, at 8:20 a.m. identified an event occured on 4/12/19, at 8:30 a.m. The investigation identifed nursing assistant (NA)-A reported to registered nurse (RN)-A NA-A had "tapped" R2 on shoulder and stated to R2 to "please to not hit us [staff]. We are trying to help you". Later on in the shift around 7:00 p.m. NA-B reported NA-A's tap was more like a "slight karate chop".

A SA report dated 4/15/19, identifed the SA was notified on 4/15/19, at 11:15 a.m. The date of incident was identifed as 4/12/19, at 6:00 p.m. The report identifed the following: "Resident was struck by staff after he had hit out at her per typical behaviors and staff reportedly put hand/arm up, in reaction, which caused resident to be struck as well. This was reported by staff involved as well as another staff in room assisting with cares. Family Aware. Nursing assistants had reported this to nurse, who contacted administrator. Reported to local law enforcement and nurse states VA [vulnerable adult report] filed. In follow up today, its noted that VA was not submitted per protocol-she was unable to log on to [SA] site and when submitting facility quality risk management report, she included [SA] email which she understood was going to be reported to state as VA this way."

When interviewed on 4/19/19, at 9:22 a.m. director of nursing (DON) stated she was not available on 4/12/19, and had not been notified of

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21995	Continued From page 3 the incident. The administrator was reported to be notified on 4/13/19, the day after the incident. During interview on 4/19/19, at 2:04 p.m. administrator stated she was notified about the incident the morning of 4/13/19, a day after the incident. Her understanding was the incident occurred just before NA-A finished her shift on 4/12/19. The administrator "walked RN-A through" making a report to the SA. Staff failed to immediately begin the process according to policy, if abuse was suspected to have occurred. The facility Adult Abuse Prevention Plan dated 1/19, directed staff to report no later than 2 hours after an allegation was made, if the events that causes the allegation involve abuse, or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Immediate reports are to be made to the administrator of the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the facility's abuse and neglect policies and procedures to ensure staff immediately report any allegation of resident abuse. The director of nursing or designee could randomly audit reports to ensure compliance. The results of the audits could be reported to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		